STATE OF VERMONT
AGENCY OF HUMAN SERVICES

P A T H

Department of Prevention, Assistance, Transition, and Health Access

B U L L E T I N NO.: 02-35

FROM: Eileen I. Elliott, Commissioner
for the Secretary

DATE: 12/18/02

SUBJECT: SFY '03 Deficit Prevention Plan for Medicaid and VHAP: Elimination of adult chiropractic services for Medicaid and VHAP, elimination of adult dentures for Medicaid, and elimination of elective hospital inpatient admissions for VHAP

CHANGES ADOPTED EFFECTIVE 1/2/03

INSTRUCTIONS

_X_ Maintain Manual - See instructions below.
___ Proposed Regulation - Retain bulletin and attachments until you receive Manual Maintenance Bulletin: _____

___ Information or Instructions - Retain until _____

MANUAL REFERENCE(S):

M621 4001.92
M640 4003

The SFY '03 Deficit Prevention Plan, which was authorized by Act 142 of 2002 and approved by the Joint Fiscal Committee of the Vermont General Assembly, calls for certain changes in Medicaid and VHAP coverage. This rule eliminates coverage of chiropractic services for VHAP and Medicaid adults. The rule suspends indefinitely coverage of dentures for adults, effectively eliminating the benefit. Finally, the rule limits VHAP coverage of inpatient hospital care to emergency and urgent admissions only (eliminating elective admissions.) Elective admissions are defined as when "the patients condition permits adequate time to schedule the availability of a suitable accommodation." The admitting physician will decide when a hospital admission is emergency, urgent, or elective.

Specific Changes to Existing Regulations

4001.92 Removes chiropractic services from the list of benefits with a cost-sharing requirement.

4003 Coverage of inpatient hospital care was reduced to urgent and emergent admissions only by change in PATH Procedures. This change eliminates referral requirement for elective admissions and no longer identifies chiropractic and dental services as wrap-around benefits.

M621 Eliminates coverage of dentures for adults.

M640 Limits coverage of chiropractic services to beneficiaries under age 21 only.

A public hearing was held on November 18, 2002, at 1:00 p.m., in the Department of PATH Blue Conference Room and moved to the DAD Conference Room, State Office Complex, Waterbury, Vermont to accommodate more people. Oral comments were recorded and transcribed. Written comments were also received. Members of the public, beneficiaries, advocates, providers and organizations affected by the proposed rule participated in the public comment process. In particular, the following organizations were heard from:

Vermont Coalition for Disability Rights
Office of Health Care Ombudsman
Fletcher Allen Health Care
Medicaid Advisory Board
Vermont State Association of Osteopathic Physicians and Surgeons
Council of Vermont Elders (COVE) and
Vermont Legal Aid

Public Comments

Comments Regarding Some or All of the Proposed Benefit Changes

Comment: Six commenters suggested that elimination of the chiropractic and dentures benefit was contrary to the Fiscal Year 2003 Appropriations Act, Act 142 at §§148(i) and (g).

Response: This legal question was raised in Washington Superior Court in the matter docketed at 687-11-02 Wncv. This suit challenged the elimination of denture coverage and chiropractic services. The court's decision concurred with the state's view that the proposed changes were consistent with the Budget Act. Specifically the court concluded that Act 142 did not exempt denture and chiropractic services from the rescissions authorized by § 324, the budget deficit prevention section.

Comment: Six commenters expressed concern about taking away benefits from the people who are least able to pay for them.

Response: State health care programs provide benefits to many individuals with limited financial resources. Any reduction in coverage will impact on the populations covered by State programs. The state has finite financial resources and recent constraints on revenues resulted in a decision to reduce the scope of benefits covered for some beneficiaries. The department decided that it was preferable to reduce benefits rather than eliminate people entirely from coverage, as it was believed that some coverage was preferable to no coverage. This decision is consistent with state and federal law that recognizes that availability of funding impacts the provision of health care services. See Act 14 (1995 Adj. Session) and *Alexander v. Choate*, 469 U.S. 287 (1995).

Comment: Three commenters objected to all of the proposed benefit cuts, because it would eliminate preventive care.

Response: The three services affected by this rule are generally not classified as preventive health services. Moreover, preventive health services, including such services as colonoscopy, mammography and PAP tests, which are primarily provided by physicians and laboratories, or in outpatient hospital settings, will continue to be covered under VHAP and traditional Medicaid.

Comment: Two commenters objected to all of the cuts - dentures, chiropractic, and VHAP inpatient hospitalization - saying that each will negatively impact the health status of low-income Vermonters, and, in the long run, increase health care costs.

Response: Unfortunately, any reductions in service will adversely impact some low income Vermonters. In light of the dire budgetary picture, it was necessary to make reductions to health care services that were of a relative lesser importance in comparison to the other services offered. Dentures are an optional service and were not a part of the Vermont Medicaid program until 1998 – from a historical perspective, this is a relatively new service addition. In addition, a recent Vermont Supreme Court decision would have required the department to cover partial dentures in addition to complete dentures. The department estimated that this would have doubled the cost of this program, thereby requiring other service reductions elsewhere. Like dentures, chiropractic coverage is an optional Medicaid service, limited to 10 visits per year for adults. Since there are other alternatives to chiropractic treatment that continue to be covered services, eliminating this optional service does not leave beneficiaries without treatment options. Finally, the changes to coverage of inpatient hospitalizations do not affect the most critical services - urgent and emergent admissions. An urgent admission is when the patient needs immediate care and the admission is scheduled for the first available bed that is right for the condition, and emergency admissions are frequently done through the emergency room. In contrast, elective admissions are defined as occurring when the patient's medical condition is such that the admission may be scheduled at another time.

Comment: One commenter wondered what happened to the cigarette tax money that Gov. Dean promised would fund health care.

Response: All proceeds from the tobacco products tax are deposited in the Health Access Trust Fund, which is used, along with other revenue sources, to fund the Medicaid and VHAP programs. The tax on tobacco products was increased in the 2002 session of the General Assembly. This increase was not enough to overcome the shortfall in general revenues that the state is projected to experience in FY 2003. No tobacco products tax has been diverted to non-healthcare spending within the budget.

Comments Regarding Elimination of VHAP Inpatient Elective Hospital Admissions

Comment: Two commenters suggested that elimination of the elective hospitalization benefit for VHAP beneficiaries was arbitrary and therefore prohibited. They believe that this is evidenced by the fact that physicians can be paid for services provided during an uncovered elective admission and that other ancillary services might be covered prior to the admission.

Response: First, when considering the elimination of VHAP benefits, it is important to consider the goal of the VHAP program. In Act 14 (1995 Session), now codified at 33 V.S.A. § 1971 et seq., the purpose section provides that "[c]onsistent with the goal of assuring universal access to health care benefits for all Vermonters, it is the purpose of this act to finance health care benefits for uninsured or underinsured low income Vermonters. **To the extent permitted by appropriations**, the revenues generated by this act will finance the existing Medicaid program and will increase the number of low income Vermonters with health benefits coverage…." Act 14 § 1 (emphasis added). Plainly, albeit unfortunately, the breadth of service coverage is dependent upon appropriations. When appropriations are not available to support all of the VHAP services, the department may scale back its range of services.

The VHAP Limited benefit, which precedes the VHAP benefit, has never included elective admissions. When the department was confronted with the necessity of making difficult program cuts to comply with the deficit reduction language in the 2003 Appropriations Act, we concluded scaling back VHAP to the VHAP Limited benefit package was a better alternative than other cuts in service. This leaves coverage for the urgent and emergency admissions intact, which are by definition more imminently serious in nature. We did not propose to reduce physician coverage under VHAP.

Comment: One commenter suggested that elimination of elective hospital admissions could result in failure to treat accidents, which could result in permanent disabling conditions.

Response: Emergency admissions will continue to be a VHAP benefit. If an individual has an accident that requires hospitalization, the admission will likely be done through the hospital emergency department, and would therefore be classified by the treating physician as an emergency admission.

Comment: Two commenters noted that elective hospital admissions are medically necessary leaving VHAP beneficiaries without such care.

Response: While this does mean some individuals on VHAP will be left without coverage for some medically necessary care, there is a distinction between covered benefits and medically necessary services. If a benefit is not covered, then the issue of medical necessity does not come into play. For example, Medicaid's fee-for-service program is prohibited by federal law from covering beneficiaries from age 22- 64 in freestanding mental hospitals, even when these services are medically necessary.

Comment: One hospital commenter suggested that its data indicate that the savings from eliminating elective coverage will be considerably higher.

Response: The commenter appears to have been calculating whole year savings rather than only 7-month savings, resulting from the benefit reductions becoming effective on November 1, 2002.

Comment: One commenter suggested that VHAP beneficiaries will likely qualify for "free care" and that "free-care" policies differ among Vermont hospitals. This could put added strain on those hospitals with more generous policies.

Response: The Department does not dispute that there may be differences in the Vermont hospitals' policies on "uncompensated care." All care for people that currently qualify for VHAP would have been uncompensated prior to the initiation of the VHAP program in 1996. Retention of emergency and urgent care coverage still pays for a significant portion of care that was "uncompensated" prior to the initiation of the VHAP program.

Comment: Four commenters expressed concerns about "cost-shifting" to the hospitals, leading eventually to increased health insurance premiums for other people and increased Medicaid costs.

Response: As noted above, the VHAP program will still cover urgent and emergency admissions that were previously "uncompensated". It is hoped that alternative therapies and outpatient services will delay or eliminate the need for elective hospital admissions.

Comment: Eight commenters suggested that elimination of the elective inpatient hospital benefit could cause care to be delayed until it becomes more serious and more costly.

Response: As noted above, alternative therapies are likely to contribute to cost savings.

Comment: Five commenters expressed concern for VHAP beneficiaries who needed certain elective surgeries in order to return to work.

Response: VHAP beneficiaries who work are generally covered by the Workers Compensation program. If the injury were work-related, it would be covered by Workers Compensation.

Comment: One commenter suggested that benefit coverage for VHAP should be stated in rule.

Response: The list of covered services for VHAP is published in VHAP Procedures, which are widely circulated and available on request. Although the department has had to modify its rules that refer to VHAP covered services, the coverage specifics have been published historically in VHAP Procedures. The department is willing to consider changing this practice in future rules.

Comments Regarding Elimination of Chiropractic Services

Comment: Three commenters suggested that elimination of the chiropractic benefit was contrary to the health insurance mandate for coverage.

Response: This legal question was raised in the Washington Superior Court lawsuit described above. The court held that state law does not require coverage of chiropractic services for Medicaid and VHAP recipients.

Comment: Eighteen commenters suggested that chiropractic savings will not be realized because patients will use more-costly, covered treatments by other providers.

Response: The only covered service performed by chiropractors for Medicaid and VHAP have been subluxations of the spine. This service is intended to address back pain. There is ongoing controversy about the efficacy of alternative treatments for low back pain. Consequently, this conclusion would be subject to professional debate. Researchers have found that chiropractic care for low back pain had similar back pain recurrence rates and functional status during recovery, but could be more expensive over time due to the frequency of visits. Cost per visit is just one factor among many in an examination of cost savings for treatment of lower back pain.

Comment: One commenter noted that the chiropractic cuts don't eliminate neuromuscular skeletal care; it only eliminates a profession from providing it.

Response: The department agrees with this statement.

Comment: One commenter expressed concern for his chiropractic patients who are currently involved in a full course of therapy that has been interrupted by the rule change. They do not have the means to pay for care without Medicaid assistance.

Response: The affordability of uncovered treatment is always a concern to our beneficiaries. The FY 2003 Budget Act had already imposed a 25% coinsurance payment ($3.50) on beneficiaries for chiropractic services. Since there are covered treatment alternatives available to recipients, the department has decided not to make any exceptions for on-going chiropractic care for covered beneficiaries.

Comment: One commenter asserted that elimination of chiropractic benefits unfairly targets his profession in a biased and prejudiced manner.

Response: Chiropractic care is an optional benefit under federal Medicaid rules. Since optional services have to be dropped in their entirety, this was one of the few that could reasonably be considered for elimination.

Comment: Two commenters expressed concern regarding access to care in the absence of Medicaid coverage of chiropractic. They stated that it would be impossible for the osteopathic community to assume the care of those Medicaid patients currently being treated by chiropractic physicians.

Response: Beneficiaries will continue to have services available that would appropriately address low back pain. Treatment of low back pain is not limited to the chiropractic profession or osteopathic physicians. Physicians, physical therapists, and medications are available to treat this condition.

Comment: Five commenters asserted that they would suffer serious physical problems without chiropractic care.

Response: Medicaid and VHAP still provide a wide range of covered services that can provide needed health care.

Comment: Four commenters said that chiropractic treatment was necessary to enable people to return to work after a back injury.

Response: There is a range of covered treatments for back injuries. In addition, work-related back injuries are subject to coverage under Workers Compensation.

Comment: Five commenters said that chiropractic treatment works much better than drugs for easing pain.

Response: Beneficiaries respond to therapies in different ways. The department is not aware of clinical evidence that supports this conclusion that chiropractic treatment is superior to drugs for pain relief. However, there is a range of covered services for the treatment of pain.

Comment: One commenter said that she needed chiropractic care to maintain her good posture and overall health.

Response: It is clinically questionable whether subluxations for "good posture and overall health" would be found "medically necessary", even if the beneficiary believes they are beneficial.

<u>Comments Regarding Elimination of Dentures</u>

Comment: Six commenters said that without needed dentures, Medicaid beneficiaries would be unable to get a job.

Response: The department understands that this is a concern, however, Medicaid is required to provide medical, not social or vocational assistance. The department is exploring ways in which TANF funds could be used for dentures to help recipients get a job.

Moreover, the department has made transitional provisions to extend coverage beyond November 1, 2002 to individuals who are already substantially along the process of obtaining dentures. Obtaining dentures can involve a long course of treatment, including extractions, healing of gums, impressions, fabrication, and fitting. Because this represents a considerable investment from patients and dentists, the intent is to ensure that individuals in the middle of a course of treatment are able to complete this course, even though the final services will extend beyond November 1, 2002.

Comment: Two commenters said that without needed dentures, Medicaid beneficiaries couldn't feed themselves well.

Response: People with few or no teeth are able to eat many foods. However, the department has an exception to coverage process for Medicaid beneficiaries where coverage is granted by the Commissioner in cases where a unique medical condition exists, and serious detrimental medical consequences are likely to result in the absence of coverage.

Comment: One commenter objected to the elimination of the dentures benefit, stating there would be no other way people could get that amount of money to pay for dentures.

Response: Again, the exception process exists for Medicaid beneficiaries with a unique medical condition where a lack of dentures would lead to serious detrimental medical consequences.

Comments Not Relevant to the Proposed Rule

Comment: One commenter said that all the state mandates have driven up the cost of health care insurance, forcing many people onto VHAP who would otherwise be able to take care of themselves.

Comment: One commenter said that state dollars should be used to fund health care, rather than to rebuild existing perfectly functional interstate rest areas.

Comment: Two commenters suggested establishing a single-payer, or "universal" health care system.

Vertical lines in the left margin indicate significant changes. Dotted lines at the left indicate changes to clarify, rearrange, correct references, etc., without changing regulation content.

Three dots at the bottom of a page after the last line of text and three dots at the top of the following page before the first line of text indicate that text has been moved.

Manual Holders: Please maintain manuals assigned to you as follows.

Manual Maintenance

Remove		Medicaid Rules	Insert	
M621	(99-12)		M621	(02-35)
M621.4	(98-11F)		M621.4 P.2	(02-35)
M640	(84-7)		M640	(02-35)
		VHAP Rules		
4001.92	(02-22)		4001.92	(02-35)
4003	(98-23F)		4003	(02-35)
4003.1	(02-22F)		4003.1	(02-35)

4001 Eligibility

4001.9 Cost Sharing in Fee-for-Service and Managed Care

4001.92 Copayment

Copayments from individuals receiving VHAP are required for certain services. Section 1916(c) of the Social Security Act stipulates that "no provider participating under the State [Medicaid] plan may deny care or services to an individual eligible for [Medicaid]... on account of such individual's inability to pay [the copayment]." This subsection further provides, however, that these requirements "shall not extinguish the liability of the individual to whom the care or services were furnished for the payment of [the copayment]." This federal statute does not apply to coinsurance, such as coinsurance for prescription drugs.

Service-specific cost-sharing liabilities are:

Physician services:	$7.00 copayment per visit
Other practitioner services:	$7.00 copayment per visit
Physical, occupational, speech and nutrition therapy services:	$7.00 copayment per visit
Hospital Inpatient	$ 50.00 copayment per admission
Outpatient hospital services not including ER services:	$25.00 per day per hospital
Emergency room:	$25.00 per visit but $60.00 if visit is not a medically necessary emergency, as defined in M103.3 (13) and (37)
Prescription drugs:	60 percent coinsurance per prescription or refill or 50 percent coinsurance when enrolled in managed health care plan. NOTE: Failure to pay the co-insurance can result in denial of service.

Coinsurance payments are limited to a calendar year maximum of $750 for a single person and $1,500 for VHAP families, when the individual or family is in managed care. The managed health care plan is responsible for letting the individual or family know when they have reached their annual out-of-pocket maximum.

No copayments or coinsurance is required for pregnant women or women in the 60-day post-pregnancy period.

4003 Benefit Delivery Systems

While enrollment in a managed health care plan will be mandatory for VHAP participants, covered services for eligible beneficiaries may be provided using a fee-for-service payment system until adequate managed care capacity is developed.

As managed care capacity becomes available in a given area, VHAP participants will be transferred into available managed care slots.

For beneficiaries required to enroll in managed health care plans, no payment will be made for services obtained outside the plan except for covered services designated as wrap-around services. (See 4003.1)

4003.1 Benefits

The VHAP-Limited benefit packages (limited and managed care) are described in procedures found at P-4003.

VHAP beneficiaries enrolled in managed health care plans can access services through the following ways:

A. Services Requiring Plan Referral

In VHAP managed care the following services, must have a referral from the beneficiary's primary care provider.

- inpatient hospital care (emergency and urgent admissions only, as determined by the admitting physician);
- outpatient services in a general hospital or ambulatory surgical center;
- physician services;
- maxillofacial surgery;
- cornea, kidney, heart, heart-lung, liver and bone marrow transplants, including expenses related to providing the organ or doing a donor search;
- home health care;
- hospice services by a Medicare-certified hospice provider;
- outpatient therapy services (home infusion therapies and occupational, physical, speech and nutrition therapy);
- prenatal and maternity care;
- ambulance services;
- medical equipment and supplies;
- skilled nursing facility services for up to 30 days length of stay per episode;

4003 Benefit Delivery Systems

4003.1 Benefits

A. Services Requiring Plan Referral (Continued) d)

- mental health and chemical dependency services;
  NOTE: If a participating managed health care plan has a contract with an institution for mental diseases, services are limited to 30 days per episode and 60 days per calendar year.
- podiatry services;
- prescription drugs and over-the-counter drugs prescribed by a physician for specific disease or medical condition;
- over-the-counter and prescription smoking cessation with a limit of two treatment regimens per beneficiary per calendar year.

B. Self-Referral Services

In VHAP managed care the following services may be accessed by beneficiaries without a referral from their primary care provider.

- one routine routine annual gynecological exam and related diagnostic services (as specified by the plan);
- one mental health and chemical dependency visit (plans may determine the number of visits beyond the initial visit that can be provided before authorization is required from the plan's mental health and substance abuse in-take coordinator, or primary care physician); and
- one routine eye examination every 24 months. (Coverage is suspended from July 1, 2002 to June 30, 2003)

C. Wrap-Around Benefits

In VHAP managed care, beneficiaries are eligible to receive additional services that are not included in the managed health care plan package. These services do not require a referral from the beneficiary's primary care provider and are reimbursed on a fee-for-service basis. The wrap-around services are:

- eyeglasses furnished through PATH’s sole source contractor (Coverage is suspended from July 1, 2002 to June 30, 2003);
- family planning services (defined as those services that either prevent or delay pregnancy).

M621 Dental Services for Beneficiaries Age 21 and older

M621.1 Definition

Dental services are preventive, diagnostic, or corrective procedures involving the oral cavity and teeth. This definition was taken from the federal definition found at 42 CFR § 440.100.

M621.2 Eligibility for Care

As of January 1, 1989, coverage of dental services was extended to beneficiaries age 21, or older.

M621.3 Covered Services

Services that have been pre-approved for coverage are limited to:

Dental services:

- prevention, evaluation and diagnosis, including radiographs when indicated;
- periodic prophylaxis;
- limited periodontal therapy;
- treatment of injuries;
- oral surgery for tooth removal and abscess drainage;
- endontics (root canal therapy);
- restoration of decayed teeth.

M621.4 Conditions for Coverage

Coverage of dental services for adults is limited to a maximum dollar amount per beneficiary per calendar year. The current maximum dollar amount is $475.

M621 Dental Services for Beneficiaries Age 21 and older

M621.4 Conditions for Coverage (Continued)

Non-surgical treatment of temporomandibular joint disorders is limited to the fabrication of an occlusal orthotic appliance (TMJ splint).

Coverage of prophylaxis is limited to once every six months, except more frequent treatments can be authorized by the department's dental consultant.

Endodontic treatment is limited to Medicaid payment for three teeth per lifetime.

Approval granted by the department's dental consultant assures medical necessity and coverage.

M621.5 Prior Authorization Requirements

Prior authorization by the PATH Dental Consultant is required for most special dental services. The Provider Manual contains a detailed list of procedures, their codes, and fee schedule. It also indicates which procedure codes require prior authorization.

M621.6 Non-Covered Services

Unless authorized for coverage via M108, services that are not covered include: cosmetic procedures; and certain elective procedures, including but not limited to: bonding, sealants, periodontal surgery, comprehensive periodontal care, orthodontic treatment, processed or cast crowns and bridges.

M640 Chiropractic Services

Services furnished by a licensed chiropractor certified to meet the standards for participation in Medicare are covered for beneficiaries under age 21 only.

Coverage is limited to treatment by means of manipulation of the spine and then only if such treatment is to correct a subluxation of the spine.

The existence of the subluxation may be demonstrated by means of:

1. An x-ray taken at a time reasonably proximate to the initiation of the course of treatment, or

2. Adherence to the clinical review criteria developed by the Vermont Chiropractic Association and the Vermont Medicaid Program. A copy of the clinical review record must be kept on file by the chiropractor and be made available upon request.

An x-ray will be considered "reasonably proximate" if:

In the case of a low grade chronic subluxation complex, it is taken no more than 12 months prior to the initiation of the course of treatment. A re-evaluation x-ray must be performed before the beginning of the third year of continuous care; or

In the case of an acute subluxation, it is taken no earlier than three months prior to the initiation of care (This would justify a course of treatment for a maximum of three months.)

Medicaid does not cover an x-ray ordered solely for the purpose of demonstrating a subluxation of the spine. Any charges incurred for the chiropractic x-ray must be borne by the recipient, recipient's family, friends or such other community resources as may be available.

Chiropractic services for recipients under the age of 12 require prior authorization from the Medical Review Unit, Medicaid Division, Waterbury. Clinical review data pertinent to the need for treatment must be submitted in writing.

Coverage is limited to ten treatments per patient per calendar year. Exceptional or unusual circumstances may justify a request by the chiropractor for additional coverage. Requests must contain full clinical data, x-rays or other documentation as may be required by the Medicaid Medical Review Unit, Medicaid Division, Waterbury, to evaluate the medical necessity for continued care.

Payment for chiropractic treatment will be made at the lower of the actual charge or the Medicaid rate on file.